EXHIBIT 19

0017857 10004

PART B

11. PERSONAL INFORMATION

All questions are to be answered by each Proposed Insured. For each yes answer, provide details below.	PROPOSED INSURED Yes	PROPOSED INSURED No	JOINT/SPOUSE PROPOSED INSURED Yes	JOINT/SPOUSE PROPOSED INSURED No	ANY CHILD Yes	ANY CHILD No
a Have you ever had any application for Life or Health Insurance (or for reinstatement for Life or Health Insurance) declined, postponed, rated-up or limited? (If yes, provide details.)	☐	☑	☐	☑	☐	☑
b Have you ever applied for or received disability payments for any illness or injury? (If yes, provide details.)	☐	☑	☐	☑	☐	☑
c. In the past 3 years have you engaged in, or do you intend to engage in: flying as a pilot, student pilot, or crew member, organized racing of an automobile, motorcycle or any type of motor-powered vehicle, scuba diving, mountain climbing, hang gliding, parachuting, sky diving, bungee jumping, or any type of body-contact or life-threatening sport? (If yes, complete an Aviation/Hazardous Activities Questionnaire.)	☐	☑	☐	☑	☐	☑
d Have you ever had your drivers license suspended or revoked or been convicted of driving while impaired or intoxicated, or been convicted in the past 3 years of more than one moving violation? (If yes, provide details.)	☐	☑	☐	☑	☐	☑
e Except as prescribed by a physician, have you ever used, or been convicted for sale or possession of cocaine or any other narcotic or illegal drug? (If yes, complete Drug Questionnaire.)	☐	☑	☐	☑	☐	☑
f. Have you ever been charged with a violation of any criminal law? (If yes, provide details.)	☑	☐	☐	☑	☐	☑
g. Have you had any bankruptcies in the past 7 years or have any suits or judgments pending against you at this time? (If yes, provide details.)	☑	☐	☐	☑	☐	☑
h Do you plan to travel or reside outside of the United States or Canada? (If yes, complete Supplement for Foreign Nationals or Travel.)	☐	☑	☐	☑	☐	☑
i. Do you belong to or intend to join any active or reserve military or naval organization? (If yes, complete Military Status Questionnaire.)	☐	☑	☐	☑	☐	☑
j. Do you have a parent or sibling who died from cancer or cardiovascular disease prior to age 60? (If yes, provide relationship to Proposed Insured(s), age at death and cause of death, and if cancer, provide type.)	☐	☑	☐	☑	☐	☑

Details of any yes answers (indicate name of person). (If more space is needed, an additional blank sheet may be attached.):

5. Canary Hunting Incident 1998 Federal Bank Fraud - Lawsuit

9. " " " 2001 Civil Action [redacted] Settled

12. TOBACCO USE

a PROPOSED INSURED:
Have you used tobacco or nicotine in any form in the last 5 years? ☐ Yes ☑ No Last 12 months? ☐ Yes ☑ No
If yes, specify the form of tobacco or nicotine products used: ☐ cigarettes ☐ pipe ☐ cigars ☐ chewing tobacco ☐ snuff ☐ other tobacco ☐ nicotine products (gum, patch, etc.)

b JOINT/SPOUSE PROPOSED INSURED:
Have you used tobacco or nicotine in any form in the last 5 years? ☐ Yes ☑ No Last 12 months? ☐ Yes ☑ No
If yes, specify the form of tobacco or nicotine products used: ☐ cigarettes ☐ pipe ☐ cigars ☐ chewing tobacco ☐ snuff ☐ other tobacco ☐ nicotine products (gum, patch, etc.)

13. PHYSICAL MEASUREMENTS

INSURED	HEIGHT	WEIGHT CURRENT	WEIGHT 1 YEAR AGO	REASON FOR WEIGHT GAIN OR LOSS
Proposed Insured	5 ft 9 in	180 lbs	156 lbs	

14. PERSONAL PHYSICIANS

	PROPOSED INSURED	JOINT/SPOUSE PROPOSED INSURED	ANY CHILD
Name of Personal Physician	Dr. Victor Gershon		
Address	[redacted] Farmington Hills, MI 48336		
Telephone Number	[redacted]		
Date last consulted	9/07		
Reason last consulted	Physical		
Treatment given or medication prescribed	Medication - Prednisone 20mg		

L-4738-21

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15. MEDICAL QUESTIONS

All questions are to be answered by each Proposed Insured. For each yes answer, circle the appropriate item and provide details in #17. To the best of your knowledge and belief, has anyone here proposed for insurance consulted a member of the medical profession for, been treated for, taken medication for, or been diagnosed as having	PROPOSED INSURED		JOINT/SPOUSE PROPOSED INSURED		ANY CHILD	
	Yes	No	Yes	No	Yes	No
a AIDS (Acquired Immune Deficiency Syndrome), or received positive results of an HIV (Human Immunodeficiency Virus) test using the ELISA-ELISA-Western Blot Testing Sequence?	☐	☑	☐	☑	☐	☑
b Heart disease including heart attack, angina, or other chest pain, high blood pressure, shortness of breath, palpitations, heart murmur, phlebitis, or any other disorder of the heart or blood vessels?	☐	☑	☐	☑	☐	☑
c Headaches, seizures, epilepsy, stroke, Alzheimer's disease, Parkinson's disease, multiple sclerosis, or any other brain or nervous disorder?	☐	☑	☐	☑	☐	☑
d Depression, neurosis, affective disorder, psychosis, or any other mental disorder?	☐	☑	☐	☑	☐	☑
e Asthma, emphysema, chronic bronchitis, tuberculosis, or any other disease of the lungs or respiratory system?	☐	☑	☐	☑	☐	☑
f Colitis, ulcer, persistent diarrhea, rectal bleeding, or any other disease or disorder of the esophagus or digestive tract?	☐	☑	☐	☑	☐	☑
g Sugar, protein or blood in the urine, kidney stones, sexually transmitted disease, or any other disease or disorder of the kidneys, bladder, prostate, breast, urinary tract or reproductive system?	☐	☑	☐	☑	☐	☑
h Diabetes, hepatitis, cirrhosis or any other disease of the liver, pancreas, or thyroid?	☐	☑	☐	☑	☐	☑
i Cancer, or any malignant or benign tumor or cyst, or any chronic disease of the skin or lymph glands?	☐	☑	☐	☑	☐	☑
j Arthritis, rheumatoid arthritis, osteoporosis, or any paralysis or chronic back or muscle condition?	☐	☑	☐	☑	☐	☑
k Alcoholism, narcotic addiction, drug use, or hallucinogens?	☐	☑	☐	☑	☐	☑
l Any disease or disorder of the eyes, ears, nose or throat?	☐	☑	☐	☑	☐	☑

16. SUPPLEMENTAL MEDICAL INFORMATION

All questions are to be answered by each Proposed Insured. For each yes answer, circle the appropriate item and provide details in #17. To the best of your knowledge and belief, in the past 5 years, has anyone here proposed for insurance:	PROPOSED INSURED		JOINT/SPOUSE PROPOSED INSURED		ANY CHILD	
	Yes	No	Yes	No	Yes	No
a Consulted, or been examined or treated by any physician, chiropractor, or other medical practitioner or by any hospital, clinic, or other medical facility not already disclosed on this application? (If it was for a "check up", annual physical, employment physical, etc., so state and give findings and results in #17)	☑	☐	☐	☐	☐	☐
b. Had any disease, disorder, injury, or operation not already disclosed on this application?	☐	☑	☐	☐	☐	☐
c. Had any x-rays, electrocardiograms, or other medical tests for reasons not already disclosed on this application?	☐	☑	☐	☐	☐	☐
d Been medically advised to have any surgery, hospitalization, treatment or test that was not completed or results that you have not received?	☐	☑	☐	☐	☐	☐

17. DETAILS OF MEDICAL HISTORY (If more space is needed, an additional blank sheet may be attached)

QUESTION # AND LETTER	PERSON	DATES	DETAILS (Be specific. Give full names, addresses and telephone number (if available) of physicians, hospitals, etc.)
16 a.	Dr. L. Scott Grant	December 200[illegible] January 2009	Checkup and prescription for a cough.

Mail To: ☒ Nationwide Life Insurance Company
☐ Nationwide Life and Annuity Insurance Company

☐ Life Underwriting	☐ COLI/BOLI, 1-11-08	☐ Group
P.O. Box 182835	One Nationwide Plaza	P.O. Box 8026
Columbus, OH 43218-2835	Columbus, OH 43215-2220	Dublin, OH 43016-9902
1-866-678-LIFE (5433)		

MEDICAL EXAMINATION

(Part 2 of an application to Nationwide Insurance for Life or Health Insurance)

Name of Proposed Insured *(please print)*	Social Security No.	Date of Birth
Gary Norman Lupiloff	[redacted]	[redacted]

Physicians: Include both primary care and specialists and date last consulted. *(If more than two physicians, indicate so under "details".)*

Name Dr. Victor C. Gruden	Name
Address 28100 Grand River Ave	Address
Telephone 248-471-3844	Telephone
Medical specialty Phys. Medicine & Rehab	Medical specialty
Date and reason last consulted 11/21/03 Blood pressure	Date and reason last consulted

Current medications to include prescription, over-the-counter medication taken regularly, dietary supplements, "natural" or herbal medications. Give details of dosage and frequency. Celebrex, Neurontin

Have you ever had any indication of, been evaluated, diagnosed, or treated by a medical professional for:	Yes	No
1a. Heart disease, including heart attack, angina or chest pain, shortness of breath, cardiomyopathy, congestive heart failure, heart murmur, or valvular heart disease, congenital heart defect, or other disorders of the heart?	☐	☒
b. Irregular heart beat, palpitations, high blood pressure, high cholesterol, or high triglycerides?	☐	☒
c. Heart catheterization, abnormal electrocardiogram, or other cardiac test, coronary bypass surgery, or angioplasty?	☐	☒
2. Aneurysm, carotid artery disease, deep venous thrombosis, phlebitis, peripheral vascular disease, any other disorder of the blood vessels, or pulmonary embolism?	☐	☒
3a. Diabetes or abnormal blood sugar?	☐	☒
b. Thyroid, adrenal, parathyroid, pituitary, or other glandular disorder?	☐	☒
4a. Cancer, leukemia, lymphoma or any malignant or benign tumor, cyst, or polyps?	☐	☒
b. Any abnormal screening tests for cancer including PSA (prostate specific antigen), mammogram, or PAP smears?	☐	☒
5. AIDS (Acquired Immune Deficiency Syndrome), or received positive results of an HIV (Human Immunodeficiency Virus) test using the ELISA-ELISA-Western Blot Testing Sequence?	☐	☒
6. Disorder of the blood including anemia, sickle cell disorders, thalassemia, hemophilia, or any other disorder of the red blood cells, platelets, or clotting factors?	☐	☒
7. Stroke, TIA, paralysis, epilepsy, seizures, fainting, tremor, Parkinson's disease, mental retardation, cerebral palsy, multiple sclerosis, Alzheimer's disease, ALS (Lou Gehrig's disease), or any other symptoms or disorders of the nerves or brain?	☐	☒
8a. Asthma, emphysema (COPD), tuberculosis, or chronic bronchitis?	☐	☒
b. Persistent hoarseness or cough, an abnormal chest X-ray or other lung disease or disorder?	☐	☒
9a. Ulcer, intestinal bleeding, ulcerative colitis, Crohn's disease, diverticulitis, hernia, or any other disorder of the esophagus, stomach, or intestines?	☐	☒
b. Jaundice, cirrhosis, hepatitis, or any disease of the liver, pancreas or gall bladder?	☐	☒
10a. Sugar, protein, or blood in the urine, kidney stone, glomerulonephritis, or history of nephrectomy?	☐	☒
b. Other disorders of the kidney, bladder, ureter, urethra, or any part of the urinary system?	☐	☒
11a. Reproductive system including uterine fibroids, endometriosis, or ovarian cyst/tumor?	☐	☒
b. Prostate enlargement, prostate cancer, testicular mass, or sexually transmitted diseases?	☐	☒
c. Other disorder of the reproductive organs or breasts?	☐	☒
12. Disorder of the muscles, joints, bones, tendons, ligaments, soft tissues, spine or back including arthritis, fracture, chronic pain, or herniated disc, chronic fatigue syndrome, or fibromyalgia?	☐	☒
13. Disease of eyes, ears, nose, or throat?	☐	☒
14a. Psychological or psychiatric disorders including depression, bipolar disorder, obsessive compulsive disorder, schizophrenia, attention deficit disorders, affective disorders, eating disorder, or any other mental or behavioral disorder or disease?	☐	☒
b. Alcoholism, drug dependency or addiction?	☐	☒
15. Any other mental or physical disease or disorder not listed above?	☐	☒

DETAILS of yes answers. Identify question number. Circle applicable items. Include diagnosis and name and address of medical provider(s) consulted. (Use page 2 if additional space is needed.)

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Nationwide Life Insurance Company
Nationwide Life and Annuity Insurance Company

MEDICAL EXAMINATION

(Part 2 (continued) of an application to Nationwide Insurance for Life or Health Insurance)

Have you in the past 10 years:	Yes	No	
16a. Been a patient (including outpatient) in a hospital, clinic, mental health facility, or other medical facility?	☐	☑	
b. Consulted or been referred to any physician not listed above?	☐	☑	
c. Been advised to have surgery, hospitalization, testing, or treatment that was not completed?	☐	☑	
17a. Used tobacco? *(If yes, specify dates and form of tobacco used.)*	☐	☑	
b. Used alcoholic beverages? *(If yes, how much, what kind (beer, wine, liquor), how often?)*	☑	☐	occrasional - social
c. Used any illegal, restricted, or controlled substance except as prescribed by a physician? *(If yes, provide details.)*	☐	☑	
18. Requested or received a pension, benefits, or payment because of injury, sickness or disability?	☐	☑	

ADDITIONAL SPACE FOR DETAILS OF YES ANSWERS. *(Identify question number.)*

19.	Living	Health Concerns or Cause of Death	Age or Age at Death	Brother or Sister?	Living	Health Concerns or Cause of Death	Age or Age at Death
Father	Y (N)	Leukemia	79		(Y) N		
Mother	(Y) N				(Y) N		
					Y N		
					Y N		

Other family members with diabetes, heart disease, cancer, kidney disease or other inheritable conditions? _____

All the statements and answers on this form are complete and true to the best of my knowledge and belief, whether written by my own hand or not; and I agree that they are to be the basis for any insurance issued hereon. I authorize: any licensed physician or medical practitioner; any hospital, clinic or other medical or medically related facility; any insurance company; the Medical Information Bureau; or any other organization, institution, or person who has knowledge of me (or of any other person who is proposed for insurance); to give that information to the Medical Director of the Nationwide Life Insurance Company, or its reinsurers. This authorization, or a copy of it, will be valid for a period of not more than thirty (30) months from the date it was signed.

Signed this day of 11 Month/Day 2003 Year

Signed _____ Signature of Medical Examiner _____ Signature of Proposed Insured

L-4693-21